

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Tollie
Township Jackson
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 700 File No. 1-2940
Primary Registration District No. 5929 Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Olga Cleverger

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <input checked="" type="checkbox"/> <u>Widowed</u>
DATE OF BIRTH <u>Nov 4, 1906</u> (Month) (Day) (Year)		
AGE <u>4</u> yrs. <u>3</u> mos. <u>8</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>✓</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u>		

BIRTHPLACE
(City or town, State or foreign country) Tollie Co Mo

PARENTS	NAME OF FATHER <u>Elias Cleverger</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tollie Co Mo</u>
	MAIDEN NAME OF MOTHER <u>Lula Tygart</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Lade Co Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS)
Jan 13 1911
Filed Jan 13 1911 A. M. Taughtlin MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan 12, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 11, 1911, to Dec 12, 1911, that I last saw her alive on Dec 12, 1911, and that death occurred, on the date stated above, at 8:10 P.M.

The CAUSE OF DEATH* was as follows:
Membranous croup

Contributory ✓
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) A. M. Taughtlin M. D.
Dec 13, 1911 (Address) Aldrich Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. in the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? ✓
Former or usual residence ✓

PLACE OF BURIAL OR REMOVAL <u>Pleasant Ridge</u>	DATE OF BURIAL <u>Dec 13 1911</u>
UNDERTAKER <u>Wilson Bros</u>	ADDRESS <u>Aldrich Mo.</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

HUGH STEPHENS, JEFFERSON CITY.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Gall
Township Jackson
Village _____
City _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 700
Primary Registration District No. 5929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. #2940
Registered No. 11

FULL NAME

Olga Klevanger

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED single
DATE OF BIRTH 11-4, 1906
AGE 4 yrs. 3 mos. 8 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Park Co - mo

PARENTS
NAME OF FATHER Chas Klevanger
BIRTHPLACE OF FATHER (City or town, State or foreign country) Park Co Mo.
MAIDEN NAME OF MOTHER Lula Dygart
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Park Co Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A J McLaughlin MD
(ADDRESS) Alburch Mo

Filed March 5, 1911 by A J McLaughlin MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 1-12- 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 12-11- 1911, to 12/12, 1911, that I last saw her alive on "11", 1911, and that death occurred, on the date stated above, at 8:10 pm. The CAUSE OF DEATH* was as follows:

menstruous cramp
(Duration) _____ yrs. _____ mos. 3 ds.

Contributory (SECONDARY) _____
(Signed) A J McLaughlin MD M. D.
12/12 1911 (Address) Alburch. Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) :
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted If not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Pleasant Ridge DATE OF BURIAL 12/13 1911
UNDERTAKER Tortson Broo - Alburch. Mo ADDRESS _____

DEC

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

{Approved by U. S. Census and American Public Health
Association}

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